

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 6 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EVA M. BAKER First Last Middle 4. DATE OF DEATH July 24 1967 Month Day Year						5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 13, 1885 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Delaware 12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Peter C. Donoway 14. MOTHER'S MAIDEN NAME Sarah E. Truitt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX (If yes give war or dates of service) XXX 16. SOCIAL SECURITY NO. 221-36-6502 17. INFORMANT Hazel Moore Address Millsboro, Delaware						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) disturbance common bile duct 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) sexualized arterio sclerosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan 1967, to 7-24, 1967, that (I) (we) last saw the deceased alive on 7-22, 1967, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE SIGNED 7/24/67 22c. PHYSICIAN'S NAME (Type) Peter Whaley Selby 22d. ADDRESS Willards, Md.						23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/26/67 23c. NAME OF CEMETERY OR CREMATORY Retzel 23d. LOCATION (City, town or county) (State) Willards, Md.					
24. FUNERAL DIRECTOR Peter Whaley Selby 25a. REC'D BY REGISTRAR JUL 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge											

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DEPARTMENT OF JUSTICE

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OFFICE OF THE ATTORNEY GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10232

CERTIFICATE OF DEATH

10231

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City 232</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>James Tenent Birch Sr.</u>		4. DATE OF DEATH <u>July 9 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Berlin MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES TENENT BIRCH</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET HILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>16-01-8586</u>	
17. INFORMANT <u>Mrs. J.T. Birch Sr.</u>		Address <u>Ocean City MD RD 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> <u>Chronic - 2° to lung C.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>67</u> , to <u>7-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-8</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>N.W. [Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Mrs. Ch. Lee</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SYNEXCENT</u>	23d. LOCATION (City or Town) (County) (State) <u>Berlin MD OR MD</u>
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10233

CERTIFICATE OF DEATH

10232

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 608 Westover Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle J. Last Birkhead		4. DATE OF DEATH Month July Day 15 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/1892
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Howard Birkhead 608 Westover Circle	
17. INFORMANT Howard Birkhead 608 Westover Circle		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus; Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to July 15, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 , and that death occurred at 6:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Hand J. Birkhead		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Hand J. Birkhead		22d. ADDRESS Hand J. Birkhead	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/1967	
23c. NAME OF CEMETERY OR CREMATORY Green Arces Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR Clinton O. Stewart		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE John J. Jones			

6890

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10234

CERTIFICATE OF DEATH

10233

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 416 Poplar Street	
3. NAME OF DECEASED (Type or print) Katie Ariettia Boyko		4. DATE OF DEATH Month July Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1915
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Artie Crisp		14. MOTHER'S MAIDEN NAME Bessie Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-8523	
17. INFORMANT Mr. Joseph Boyko		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene of foot		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/27 , 19 67 , to 7/21 , 19 67 , that (I) (we) last saw the deceased alive on 7/21 , 19 67 , and that death occurred at 9P M, from causes and on the date stated above.			
22a. SIGNATURE Richard E. Hughes		22b. DATE SIGNED 7/22/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Thomas F. Wallace		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

STATE OF TEXAS

10334

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10/15/1918		Dallas, Texas	
Cause of Death		Disease		Injury		Poison		Other		Remarks	
Heart Disease		Tuberculosis		Falls		Arsenic		Suicide		None	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use	
Teacher		High School		Married		None		Occasional		Daily	
Signature of Physician		Signature of Coroner		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Burial	
J. H. Smith		W. B. Jones		C. D. Brown		John Doe		Mary Doe		John Doe	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

10235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10234

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Box 5	
3. NAME OF DECEASED (Type or print) First EMLYN Middle JAMES Last BRITTON		4. DATE OF DEATH Month 7 Day 15 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-47
9. AGE (In years lost birthday) yrs. 20		10. IF UNDER 1 YEAR Months 20 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Britton		14. MOTHER'S MAIDEN NAME Ellen French Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James E. Britton		Address Manokin, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Rupture of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH hours
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that failed to make a curve and overturned.	
20c. TIME OF INJURY Month, Day, Year 9:30 7-14-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 313, north of Mardela, Wicomico, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED July 17, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave, Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition (Type)	23b. DATE THEREOF 7/17/1967	23c. NAME OF CEMETERY OR CREMATORY MANOKIN CEMETERY	23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.
24. FUNERAL DIRECTOR Wilson Funeral Home, Princess Anne, Md.		25a. REC'D BY REGISTRAR JUL 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10236

CERTIFICATE OF DEATH

10235

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY in 1b 46 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			22-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle L. Last Callaway				4. DATE OF DEATH Month July Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/05		9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Pants Factory		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Ernest Callaway				14. MOTHER'S MAIDEN NAME Ella M. Joseph			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 148100129		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 465X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) out to (c) Arteriosclerotic Cardio-Vascular Disease							INTERVAL BETWEEN ONSET AND DEATH 3 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/31/67 , 19__ to 7/15/67 , 19__, that (I) (we) last saw the deceased alive on 7/15/67 , 19__, and that death occurred at 5:55 M. from causes and on the date stated above.							
22a. SIGNATURE L. Maldve, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 16, 1967	
22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.				22d. ADDRESS Deer's Head State Hospital, Box 2018, Salisbury			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/67	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel, Del.		
24. FUNERAL DIRECTOR W. J. Harrison				25a. REC'D BY REGISTRAR DATE JUL 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

STATEMENT OF FACTS

102330

Washington, D.C.

January 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 11th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,

W. H. HARRIS, Director

Enclosed for you are two copies of a report on the subject of the proposed new plant industry.

Very respectfully,
W. H. HARRIS

Enclosed for you are two copies of a report on the subject of the proposed new plant industry.

Very truly,
W. H. HARRIS

102330

Very truly,
W. H. HARRIS

Very truly,
W. H. HARRIS

Very truly,
W. H. HARRIS

Very truly,
W. H. HARRIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 219 Morris Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT First MEREDITH Middle CHANDLER Last				4. DATE OF DEATH Month 7 Day 1 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1915		9. AGE (in years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar M. Chandler				14. MOTHER'S MAIDEN NAME Hattie W. Nock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215 12 6707		17. INFORMANT Mrs. Mabel J. Chandler, see # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Phillip A. Insley				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-3-67	
EXAMINER'S NAME (Type) Phillip A. Insley, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1967		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Franklin B. Hill				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR JUL 8 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10238

CERTIFICATE OF DEATH

10237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 367	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL CORD Chapman		4. DATE OF DEATH Month July Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1867
9. AGE (In years, lost birthday) 99 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOAT BUILDER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) CHAPMAN TOWN VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL J. CHAPMAN		14. MOTHER'S MAIDEN NAME JANE PATTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-8373T	
17. INFORMANT Mrs Lora Collins Berlin Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death 5615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Stagnated Heart		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5:30 P.M. from causes on and on the date stated above.			
22a. SIGNATURE N. W. Todd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) N. W. Todd		22d. ADDRESS Md. Co. Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/23/67	
23c. NAME OF CEMETERY OR CREMATORY GREENBACKVILLE		23d. LOCATION (City or Town) (County) (State) GREENBACKVILLE Acco. VA	
24. FUNERAL DIRECTOR Anne A. Burboze Berlin Md		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

11536

DATE OF DEATH

1968

PLACE OF DEATH

NAME

SEX

AGE

CAUSE OF DEATH

ICD-9 CODE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

1. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

2. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

3. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

4. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

5. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

6. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

7. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

8. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

9. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

10. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, as far as I know.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 318 Naylor Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last CHATHAM					4. DATE OF DEATH Month July Day 18 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1876		9. AGE (In years last birthday) 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Delmar, Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jonathan Beach					14. MOTHER'S MAIDEN NAME Mary E. Gordy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-48-6539J1		17. INFORMANT Mrs. Irene C. Shores (Daughter) 319 Naylor St., Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>Coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Urinary infection</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/18/67 to 7/18/67, that (I) (we) last saw the deceased alive on 7/18/67, and that death occurred at 9 PM, from the causes and on the date stated above.									
22a. SIGNATURE <i>Carrie I. Hearn</i> 22c. PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 226 N. Division Street, Salisbury, Md.		22b. DATE SIGNED July 7/20/67		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. RECEIVED BY REGISTRAR DATE JUL 24 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

SAVORY & COMPANY, SALESBURY, HAYWARD

July 21, 1952 Person Enrolled

SALESBURY, HAYWARD

JUL 24 1952

SALESBURY, HAYWARD

325 N. Division Street, Salesbury, Pa.

SALESBURY, HAYWARD

SALESBURY, HAYWARD

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #G391 7/31/67 ph

10240

CERTIFICATE OF DEATH

10239

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover Somerset County 1962			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Box 254		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Edward Collins				4. DATE OF DEATH Month Day Year 7 20 1967			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/1902	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Westover, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel J. Collins				14. MOTHER'S MAIDEN NAME Elizabeth Fooks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-61-6486		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident ← 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of stomach → (c) 6/21/67 → 7/20/67 INTERVAL BETWEEN ONSET AND DEATH July 20, 1967							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 21, 1967 , to July 20, 1967 , that (I) (we) last saw the deceased alive on July 20, 1967 , and that death occurred at 10:20 A.M. from causes and on the date stated above.							
22a. SIGNATURE Youngsik Moon				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 20, 1967	
22c. PHYSICIAN'S NAME (Type) Youngsik Moon, M.D.				22d. ADDRESS Peninsula Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-23-67		23c. NAME OF CEMETERY OR CREMATORY St. James		23d. LOCATION (City or Town) (County) (State) Westover, Md.	
24. FUNERAL DIRECTOR William J. James				25a. REC'D BY REGISTRAR JUL 26 1967		25b. REGISTRAR'S SIGNATURE James J. James	

1991-1992 1993-1994 1995-1996 1997-1998 1999-2000 2001-2002 2003-2004 2005-2006 2007-2008 2009-2010 2011-2012 2013-2014 2015-2016 2017-2018 2019-2020 2021-2022 2023-2024 2025-2026 2027-2028 2029-2030 2031-2032 2033-2034 2035-2036 2037-2038 2039-2040 2041-2042 2043-2044 2045-2046 2047-2048 2049-2050 2051-2052 2053-2054 2055-2056 2057-2058 2059-2060 2061-2062 2063-2064 2065-2066 2067-2068 2069-2070 2071-2072 2073-2074 2075-2076 2077-2078 2079-2080 2081-2082 2083-2084 2085-2086 2087-2088 2089-2090 2091-2092 2093-2094 2095-2096 2097-2098 2099-2100 2101-2102 2103-2104 2105-2106 2107-2108 2109-2110 2111-2112 2113-2114 2115-2116 2117-2118 2119-2120 2121-2122 2123-2124 2125-2126 2127-2128 2129-2130 2131-2132 2133-2134 2135-2136 2137-2138 2139-2140 2141-2142 2143-2144 2145-2146 2147-2148 2149-2150 2151-2152 2153-2154 2155-2156 2157-2158 2159-2160 2161-2162 2163-2164 2165-2166 2167-2168 2169-2170 2171-2172 2173-2174 2175-2176 2177-2178 2179-2180 2181-2182 2183-2184 2185-2186 2187-2188 2189-2190 2191-2192 2193-2194 2195-2196 2197-2198 2199-2200 2201-2202 2203-2204 2205-2206 2207-2208 2209-2210 2211-2212 2213-2214 2215-2216 2217-2218 2219-2220 2221-2222 2223-2224 2225-2226 2227-2228 2229-2230 2231-2232 2233-2234 2235-2236 2237-2238 2239-2240 2241-2242 2243-2244 2245-2246 2247-2248 2249-2250 2251-2252 2253-2254 2255-2256 2257-2258 2259-2260 2261-2262 2263-2264 2265-2266 2267-2268 2269-2270 2271-2272 2273-2274 2275-2276 2277-2278 2279-2280 2281-2282 2283-2284 2285-2286 2287-2288 2289-2290 2291-2292 2293-2294 2295-2296 2297-2298 2299-2300 2301-2302 2303-2304 2305-2306 2307-2308 2309-2310 2311-2312 2313-2314 2315-2316 2317-2318 2319-2320 2321-2322 2323-2324 2325-2326 2327-2328 2329-2330 2331-2332 2333-2334 2335-2336 2337-2338 2339-2340 2341-2342 2343-2344 2345-2346 2347-2348 2349-2350 2351-2352 2353-2354 2355-2356 2357-2358 2359-2360 2361-2362 2363-2364 2365-2366 2367-2368 2369-2370 2371-2372 2373-2374 2375-2376 2377-2378 2379-2380 2381-2382 2383-2384 2385-2386 2387-2388 2389-2390 2391-2392 2393-2394 2395-2396 2397-2398 2399-2400 2401-2402 2403-2404 2405-2406 2407-2408 2409-2410 2411-2412 2413-2414 2415-2416 2417-2418 2419-2420 2421-2422 2423-2424 2425-2426 2427-2428 2429-2430 2431-2432 2433-2434 2435-2436 2437-2438 2439-2440 2441-2442 2443-2444 2445-2446 2447-2448 2449-2450 2451-2452 2453-2454 2455-2456 2457-2458 2459-2460 2461-2462 2463-2464 2465-2466 2467-2468 2469-2470 2471-2472 2473-2474 2475-2476 2477-2478 2479-2480 2481-2482 2483-2484 2485-2486 2487-2488 2489-2490 2491-2492 2493-2494 2495-2496 2497-2498 2499-2500 2501-2502 2503-2504 2505-2506 2507-2508 2509-2510 2511-2512 2513-2514 2515-2516 2517-2518 2519-2520 2521-2522 2523-2524 2525-2526 2527-2528 2529-2530 2531-2532 2533-2534 2535-2536 2537-2538 2539-2540 2541-2542 2543-2544 2545-2546 2547-2548 2549-2550 2551-2552 2553-2554 2555-2556 2557-2558 2559-2560 2561-2562 2563-2564 2565-2566 2567-2568 2569-2570 2571-2572 2573-2574 2575-2576 2577-2578 2579-2580 2581-2582 2583-2584 2585-2586 2587-2588 2589-2590 2591-2592 2593-2594 2595-2596 2597-2598 2599-2600 2601-2602 2603-2604 2605-2606 2607-2608 2609-2610 2611-2612 2613-2614 2615-2616 2617-2618 2619-2620 2621-2622 2623-2624 2625-2626 2627-2628 2629-2630 2631-2632 2633-2634 2635-2636 2637-2638 2639-2640 2641-2642 2643-2644 2645-2646 2647-2648 2649-2650 2651-2652 2653-2654 2655-2656 2657-2658 2659-2660 2661-2662 2663-2664 2665-2666 2667-2668 2669-2670 2671-2672 2673-2674 2675-2676 2677-2678 2679-2680 2681-2682 2683-2684 2685-2686 2687-2688 2689-2690 2691-2692 2693-2694 2695-2696 2697-2698 2699-2700 2701-2702 2703-2704 2705-2706 2707-2708 2709-2710 2711-2712 2713-2714 2715-2716 2717-2718 2719-2720 2721-2722 2723-2724 2725-2726 2727-2728 2729-2730 2731-2732 2733-2734 2735-2736 2737-2738 2739-2740 2741-2742 2743-2744 2745-2746 2747-2748 2749-2750 2751-2752 2753-2754 2755-2756 2757-2758 2759-2760 2761-2762 2763-2764 2765-2766 2767-2768 2769-2770 2771-2772 2773-2774 2775-2776 2777-2778 2779-2780 2781-2782 2783-2784 2785-2786 2787-2788 2789-2790 2791-2792 2793-2794 2795-2796 2797-2798 2799-2800 2801-2802 2803-2804 2805-2806 2807-2808 2809

3

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		c. LENGTH OF STAY IN lb <u>44 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		<u>22-1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year					
<u>William Thomas Couch Sr.</u>				<u>7 - 7</u>		<u>1967</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>2/15/1884</u>	<u>83</u> yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw mill operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13. FATHER'S NAME <u>William T. Couch</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Hambar</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-6319</u>		17. INFORMANT <u>Joseph M. Couch, Jr.</u>		Address <u>53136 Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Advanced Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
<u>19</u>		<u>Mar 11</u>		<u>1966</u>		<u>7/7</u>		<u>1967</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 11</u> 19 <u>66</u> to <u>7/7</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/20</u> 19 <u>67</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>David J. Gilmore</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/10/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>David J. Gilmore, M.D.</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico Episcopal Com.</u>		23d. LOCATION (City, town or county) (State) <u>Quantico Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Mossie, Jr.</u>		ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>					

2352

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10241

10242

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30.4		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 805 N. Fremont Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Carrie		Middle B.		Last Custis		4. DATE OF DEATH Month 7		Day 1		Year 1967		5. SEX Female		6. COLOR OR RACE Negro					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 7		11. IF UNDER 24 HRS. Days 1		12. HOURS 1		13. MIN. 67		14. BIRTHPLACE (County & State, or foreign country) Accomac VA.					
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		16. KIND OF BUSINESS OR INDUSTRY Domestic		17. BIRTHPLACE (County & State, or foreign country) Accomac VA.		18. CITIZEN OF WHAT COUNTRY? U.S.A		19. FATHER'S NAME Abel Wise		20. MOTHER'S MAIDEN NAME Caroline Brown		21. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		22. SOCIAL SECURITY NO. 217-10-3631					
23. INFORMANT Fred Wise		24. ADDRESS 230 Delaware Ave. Sals.		25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus of small intestine 5903 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease w/aortic stenosis DUE TO (c) Years		26. INTERVAL BETWEEN ONSET AND DEATH 2 days		27. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		29. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		30. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		31. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		32. 20f. (City or town) (County) (State)	
33. 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.		34. 22a. SIGNATURE W. Walder		35. 22b. DATE SIGNED		36. 22c. PHYSICIAN'S NAME (Type)		37. 22d. ADDRESS		38. 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		39. 22f. DATE SIGNED		40. 22g. SIGNATURE					
41. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		42. 23b. DATE THEREOF 7-5-67		43. 23c. NAME OF CEMETERY OR CREMATORY Accomac		44. 23d. LOCATION (City or Town) (County) (State) Accomac Accomac VA		45. 23e. REC'D BY REGISTRAR JUL 7 1967		46. 23f. REGISTRAR'S SIGNATURE Charles J. J...		47. 23g. FUNERAL DIRECTOR Louella B. Jolley		48. 23h. ADDRESS Jersey Rd. P.O. #2 Salisbury, Md.					

WILLIAMSON'S DIETARY FIBER SUPPLEMENT

3252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10243

10242

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23.2</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Rt #1 Box 296-A</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Clifton EMORY DALE</u>		First Middle Last		4. DATE OF DEATH <u>July 4 1967</u>		Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1914</u>	9. AGE (In years lost birthday) <u>52</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SNOW HILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dale</u>				14. MOTHER'S MAIDEN NAME <u>Lottie Bowen</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hazel Dale</u> Address <u>Rt #1 Box 296-A Snow Hill, Md</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Myocardial Hypertension & Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6-29</u> , 19 <u>67</u> to <u>7-4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-4</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>James J. Coffey</u> M.D.				22b. DATE SIGNED <u>7-6-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Westley</u>		23d. LOCATION (City or Town) (County) (State) <u>SNOW HILL Wore. Md.</u>				
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Jersey Rd. Rt #3 Salis</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jolley</u>				

48

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10244

10243

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d. STREET ADDRESS 2621 Windsor Road			
3. NAME OF DECEASED (Type or print) First AGNES Middle M. B. Last DAUER				4. DATE OF DEATH Month 7 Day 25 Year 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-09	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer & housewife				10b. KIND OF BUSINESS OR INDUSTRY Electronics Mfg.		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Christophe F. Bory				14. MOTHER'S MAIDEN NAME Agnes K. Schaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-03-2744				16. SOCIAL SECURITY NO. 216-10-2409			
17. INFORMANT Ms. Agnes K. Bory (mother)				18. ADDRESS same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 2892 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemochromatosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				22. DATE SIGNED July 25, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 19 67		23c. NAME OF CEMETERY OR CREMATORY Brooklawn	
24. FUNERAL DIRECTOR Curtis Evans Funeral Home, Baltimore, Md.				25a. REC'D BY REGISTRAR JL 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE OFFICE OF THE ATTORNEY GENERAL
STATE OF TEXAS

W. L. G.

10245

10244

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Sharptown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beatrice Middle ETTA / (PATTON)		4. DATE OF DEATH Lost ECHARD Month 7 Day 18 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1892
9. AGE (In years last birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (County & State, or foreign country) Fairfield, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Basil H. Patton		14. MOTHER'S MAIDEN NAME Annie Julia Pickrel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-1862-A	
17. INFORMANT Mr. S. Lyle Echard (Son)		Address Sharptown Road, Mardeia, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2021 IMMEDIATE CAUSE (a) Lymphoblastoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 11, 1967 , to July 18, 1967 , that (I) (we) last saw the deceased alive on July 18, 1967 , and that death occurred at 8:55 AM , from causes and on the date stated above			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10246

CERTIFICATE OF DEATH

10245

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 833	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 1114 No. Stuart Street	
3. NAME OF DECEASED (Type or print) First LESLIE Middle CECIL Last Eggleston		4. DATE OF DEATH Month July Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1900
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. (Ret.)	
11. BIRTHPLACE (County & State, or foreign country) Greenbrier County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Eggleston		14. MOTHER'S MAIDEN NAME Virginia Hepler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-7417	
17. INFORMANT Mrs Ethel V. Eggleston		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease (c) Arteriosclerotic Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/24/67 to 7/24/67 that (I) (we) last saw the deceased alive on 7/24/67 and that death occurred at 5:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/27/67	23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR Mac H. Momin Arlington Funeral Home		25a. REC'D BY REGISTRAR Fairfax Dr. Ar	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE JUL 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10247

CERTIFICATE OF DEATH

10246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 152 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 405 W. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PANSY Middle ELIZABETH Last FIELDS				4. DATE OF DEATH Month 7 Day 16 Year 19 67			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1893	
9. AGE (In years lost, birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 16		IF UNDER 24 HRS. Hours 16 Min. 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Operator & OWNER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Ida Belle Driscoll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-32-0350		17. INFORMANT Mr. Harry Matthew Fields (Husband) 405 W. Main Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, right base 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured pelvis, healed							INTERVAL BETWEEN ONSET AND DEATH 11 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 14, 1967 , to July 16, 1967 , that (I) (we) last saw the deceased alive at July 16, 1967 , and that death occurred at 4:55 PM , from causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/17/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico Co., Md.	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10343

CHARTER OF DEATH

11/10/1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10248

CERTIFICATE OF DEATH

10247

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b DELMAR.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R 2 1	
3. NAME OF DECEASED (Type or print) Louise First Middle Last FOXWELL		4. DATE OF DEATH JULY 29 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1911
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Emory Heorn		14. MOTHER'S MAIDEN NAME Molly Beauchamp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Morton Hopwell Address Delmar Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of breast DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/28/67 , 19 67 , to 7/29/67 , 19 67 , that (I) (we) last saw the deceased alive on 7/29/67 , 19 67 , and that death occurred at 1:30 M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Hughes		22b. DATE SIGNED 7/29/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/1/67	23c. NAME OF CEMETERY OR CREMATORY Hatlings Cem	23d. LOCATION (City or Town) (County) (State) Delmar Sussex Md.
24. FUNERAL DIRECTOR William M. Morris		25a. REC'D BY REGISTRAR Charles Judge DATE AUG 1 1967	

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WILSON

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

Page 1 of 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10249

10248

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d. STREET ADDRESS Route 1			
3. NAME OF DECEASED (Type or print) First Middle Last MAMIE GALE				4. DATE OF DEATH Month Day Year 7-25-67 19			
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-01	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randall Horsey				14. MOTHER'S MAIDEN NAME Annie Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence Horsey Address Wolf St. Laurel Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 5411 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.		EXAMINER'S NAME (Type) Earl L. Royer, M.D.		22. DATE SIGNED July 28, 1967		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/67		23c. NAME OF CEMETERY OR CREMATORY Quantico Cemetery		23d. LOCATION (City or town) (County) (State) Quantico Wicomico Md.	
24. FUNERAL DIRECTOR Clinton Stewart Clinton Stewart Funeral Home, Salisbury, Md.				25a. REC'D BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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JUN 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10250

CERTIFICATE OF DEATH

10249

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS - -	
3. NAME OF DECEASED (Type or print) First OLIVE Middle PUSEY Last GIBBONS		4. DATE OF DEATH Month 7 Day 24 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1884
9. AGE (In years last birthday) 83 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co.; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John U. Cantwell		14. MOTHER'S MAIDEN NAME Edora Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Old Quantico Rd. Mrs. Mary Davis Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Monday	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 , to July 24 , 19 67 , that (I) (we) last saw the deceased alive on July 24 , 19 67 , and that death occurred at 2:30 PM , from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/26/67	
23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		23d. LOCATION (City or Town) (County) (State) Perryhawkin; Somerset Co. Md.	
24. FUNERAL DIRECTOR James L. Luman		25a. REC'D BY REGISTRAR Princess Anne, Md.	
25b. REGISTRAR'S SIGNATURE J. Charles Jones		25c. DATE JUL 28 1967	

10220

CERTIFICATE OF DEATH

Completed

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10251 CERTIFICATE OF DEATH 10250

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Frankford</u> 463			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springhill Sanitarium Inc.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry A. Godwin Sr.</u>				4. DATE OF DEATH Month Day Year <u>July 7 19 67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/10/1877</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF FUNDER 1 YEAR Months Days		IF FUNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ebe W. Godwin</u>				14. MOTHER'S MAIDEN NAME <u>Hettie Godwin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>221-24-3133</u>		17. INFORMANT Address <u>A (Mary Anna Godwin) Frankford, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with metastases</u> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>18 mon.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond M. Yar</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roxana Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Roxana, Delaware</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10252

10251

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydie Wesley First Middle Last				4. DATE OF DEATH July 11 1967 Month Day Year			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1878	
9. AGE (In years, months, days, hours, minutes) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Waterman & Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.	
13. FATHER'S NAME George Hall				14. MOTHER'S MAIDEN NAME Elizabeth Lawrence			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address George Hall, Monie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7:10 , 19 67 , to 7:11 , 19 67 , that (I) (we) last saw the deceased alive on 7:10 , 19 67 , and that death occurred at 6:57 A.M. from causes and on the date stated above.							
22a. SIGNATURE H. Briele				23. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-11-67	
22c. PHYSICIAN'S NAME (Type) H. Briele				22d. ADDRESS Medical Center Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/67		23c. NAME OF CEMETERY OR CREMATORY Beechwood		23d. LOCATION (City or Town) (County) (State) Princess Anne; Somerset Co. Md.	
24. FUNERAL DIRECTOR James Hannon				25a. REC'D BY REGISTRAR DATE JUL 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

10223

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10253

CERTIFICATE OF DEATH

10252

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Edwin Hayman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hayman</u>		14. MOTHER'S MAIDEN NAME <u>Mae Estelle Le Compton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Madge Hayman</u>		Address <u>Princess Anne Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>67</u> to <u>7-24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>67</u> , and that death occurred <u>2:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>W. Bellis, Jr.</u>		22b. DATE SIGNED <u>7-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne Md.</u>
24. FUNERAL DIRECTOR <u>Levin R. Wilson</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

OFFICE OF THE ATTORNEY GENERAL

10328

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Attorney General" and "Department of Health" are faintly visible.]

[Vertical text on the right margin, likely bleed-through from the reverse side. It appears to contain a date and some administrative notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10254

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10253

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 65 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. STREET ADDRESS P.O. Box 244	
3. NAME OF DECEASED (Type or print) First JEFFERSON Middle HENRY Last HENRY		4. DATE OF DEATH Month 7 Day 26 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3, 1906
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) UNKNOWN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 265-14-3095	
17. INFORMANT Henry Drwin		Address Marbury Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple decubiti DUE TO (c) Chronic rheumatoid arthritis		INTERVAL BETWEEN ONSET AND DEATH 14 days 9 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 22 , 19 67 , to July 26 , 19 67 , that (I) (we) last saw the deceased alive on July 26 , 19 67 , and that death occurred at 12:00 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Chas. H. Winnacott		22b. DATE SIGNED 7/26/67	
22c. PHYSICIAN'S NAME (Type) Chas. H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/27/67	23c. NAME OF CEMETERY OR CREMATORY Bark Hill	23d. LOCATION (City or town) (County) (State) Marbury Md.
24. FUNERAL DIRECTOR Archart Funeral Home		25. REC'D BY REGISTRAR Lab. 1	
25a. DATE AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10255

CERTIFICATE OF DEATH

10254

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Old Stage Rd., R.D.#1	
3. NAME OF DECEASED (Type or print) First Middle Last HONEY LYNN Hobbs		4. DATE OF DEATH Month Day Year JULY 30 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1967
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		9. AGE (In years last birthday) 0 yrs. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland	
13. FATHER'S NAME George Jerry Hobbs		14. MOTHER'S MAIDEN NAME MARY ELIZABETH SAVAGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mr. George J. Hobbs (Father) R.D.#1, Delmar, Delaware		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 7-30 , 19 67 , to 7-30 , 19 67 that (I) (we) last saw the deceased alive on 7-30 , 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Wm B Smith		22b. DATE SIGNED 7/30/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM B. SMITH		22d. ADDRESS 5. DIVISION ST, SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY FUNERAL HOME, SALISBURY, MD.		25a. REC'D BY REGISTRAR AUG 1 1967	
25b. REGISTRAR'S SIGNATURE J Charles Juge		25c. REGISTRAR'S SIGNATURE J Charles Juge	

10884

CERTIFICATE OF DEATH

Recorded

1911

Deceased (Name) [illegible]

Age [illegible]

[illegible]

[illegible]

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14

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #1d Film #G397 8/7/67 ph & Item #7

10256

CERTIFICATE OF DEATH

10255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN lb <u>All Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>corner Jersey Rd. & Hearne Lane</u>				d. STREET ADDRESS <u>Jersey Road Rt #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Olvin</u> Middle <u>Alex</u> Last <u>Holbrook</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-6-1906</u>		9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Venton</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Parson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-3501</u>		17. INFORMANT <u>Edw Newborns</u>		Address <u>Jersey Rd Rt #2 Salisbury, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 July 1967</u> to <u>27 July 1967</u> , that (I) (we) last saw the deceased alive on <u>27 July 1967</u> , and that death occurred at <u>3 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>J. F. Purnell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>28 Aug 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. F. Purnell, M.D.</u>				22d. ADDRESS <u>652 W. Main St., Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		23d. LOCATION (City or town) (County) (State) <u>Venton Somerset Md.</u>	
24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u>				ADDRESS <u>Jersey Rd. Rt #2 Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF NEW YORK
IN SENATE
JANUARY 12, 1900

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1899.

THE LAND OFFICE OF THE STATE OF NEW YORK, under the direction of the COMMISSIONER, has the honor to acknowledge the receipt of the REPORT OF THE COMMISSIONER OF THE LAND OFFICE, for the year 1899, and to transmit herewith a copy of the same to the SENATE, and to the HOUSE OF REPRESENTATIVES, for their consideration.

Very respectfully,
J. B. LIPPINCOTT & CO.,
PRINTERS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10257

CERTIFICATE OF DEATH

10256

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island		d. STREET ADDRESS Deer's Head State Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRENE Middle HOOPER Last HOOPER		4. DATE OF DEATH Month 7 Day 24 Year 19 67	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1902
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sea Food Pkg.	
11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Todd		14. MOTHER'S MAIDEN NAME Susan Travers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-9691A	
17. INFORMANT Carlos Hooper, Taylors Island, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) yes		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 18 , 19 67 , to July 24 , 19 67 , that (I) (we) last saw the deceased alive on July 24 , 19 67 , and that death occurred at 2:25 PM , from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/1967	
23c. NAME OF CEMETERY OR CREMATORY Linas Road Cemetery		23d. LOCATION (City or Town) (County) (State) Dorchester Co. Md.	
24. FUNERAL DIRECTOR Frederick C. [Signature]		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles [Signature]			

STATE OF NEW YORK
IN SENATE
January 10, 1923

MEMORANDUM OF DECISION

1923

James J. ...

...

...

...

Charles V. ...
Charles V. ...

[Signature]

A. J. ...

...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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VR A15
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10258 Item #7 Film #G-91 8/3/67 ph 10257											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY _____						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 30.4						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Shade Nursing Home.					d. STREET ADDRESS 3808 White Ave.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Anna Middle Lewis Last Howard					4. DATE OF DEATH Month July Day 30 Year 1967						
5. SEX Female					6. COLOR OR RACE White						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Sept. 13, 1877						
9. AGE (In years last birthday) 89 yrs.					10. IF UNDER 1 YEAR Months 10 Days 17 Hours 17 Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY _____						
11. BIRTHPLACE (County & State, or foreign country) Mardela, Maryland.					12. CITIZEN OF WHAT COUNTRY? U.S. A.						
13. FATHER'S NAME Thomas Newton Evans					14. MOTHER'S MAIDEN NAME Mary Hurley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No					16. SOCIAL SECURITY NO. _____						
17. INFORMANT Mrs. Lelia Walker, Mardella Spring, Md.					Address _____						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Gall Bladder DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____										INTERVAL BETWEEN ONSET AND DEATH 16 hr -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) _____										20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 7/29 , that (I) (we) last saw the deceased alive on 7/28 , 1967 , and that death occurred at 1:00 AM , from the causes and on the date stated above.											
22a. SIGNATURE H.S. Kuhlman M.D.										22b. DATE SIGNED 7/30/67	
22c. PHYSICIAN'S NAME (Type) H.S. Kuhlman										22d. ADDRESS Sharpton Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment.										23b. DATE THEREOF 8/3/67.	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum										23d. LOCATION (City, town or county) _____ (State) _____ Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. Balto. Md. 21214										25a. REC'D BY REGISTRAR DATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge											

10255

Baltimore

Female

People's Radio Bureau, Home.

Anna

Leola

Howard

July 30.

1918. 10 17

Female

Female

Thomas Newton Evans

Mary Emily

Mrs. John A. Allen, Lardella Service, Md.

Baltimore, Md.

Johnnie Langston

Baltimore

Edward J. Cook, Inc. Radio, Md. State

July 1 1918

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10253

10258

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pittsville				c. LENGTH OF STAY IN lb Pittsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) In village				d. STREET ADDRESS (in village)			
3. NAME OF DECEASED (Type or print) JOHNNIE FRANK HUDSON				4. DATE OF DEATH Month July Day 7 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1901	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 2 Days 9		IF UNDER 24 HRS. Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming			
11. BIRTHPLACE (County & State, or foreign country) Near Pittsville, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Henry Hudson				14. MOTHER'S MAIDEN NAME Viola S. Poor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-32-2151		17. INFORMANT Mrs. Myrtle P. Hudson (Wife) Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial Infarction DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 7, 1967 to July 7, 1967 , that (I) (we) last saw the deceased alive on July 7, 1967 , and that death occurred at 5:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE William D. Gray				22b. DATE SIGNED July 8, 1967		22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray	
22d. ADDRESS 334 Camden Avenue, Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery		23d. LOCATION (City, town or county) (State) R.D., Parsonsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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2754

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10260

CERTIFICATE OF DEATH

10259

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Girdletree	
3. NAME OF DECEASED (Type or print) First Matherine Middle M. Last Hudson		4. DATE OF DEATH Month July Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Girdletree, Md	
13. FATHER'S NAME Calah Watson		14. MOTHER'S MAIDEN NAME Mary F. Wickham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT William A. Hudson, Girdletree Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA GALL BLADDER DUE TO (c) 1 YEAR		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 , 1967, to 7/16 , 1967, that (I) (we) last saw the deceased alive on 7/16 , 1967, and that death occurred at 10A M, from causes and on the date stated above.			
22a. SIGNATURE John M. Bluxom III		22b. DATE SIGNED 7/16/67	
22c. PHYSICIAN'S NAME (Type) JOHN M. BLUXOM III		22d. ADDRESS MEDICAL CENTER, SALISBURY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		23d. LOCATION (City or Town) (County) (State) Girdletree, Md.	
24. FUNERAL DIRECTOR William F. ... Snow H. H. Md.		25a. REC'D BY REGISTRAR DATE JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10261

CERTIFICATE OF DEATH

10260

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dagsboro 46.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Merrill Middle Dee Last Hudson		4. DATE OF DEATH Month July Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1925
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Hudson		14. MOTHER'S MAIDEN NAME Lillie Hudson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 222-12-0597	
17. INFORMANT Catherine E. Hudson, Dagsboro, Del.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism suspected DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Small thrombosis right ventricle suspected DUE TO (c) Myocardial Infarction + A.S.C.V.D.		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-12-67 , 19 67 , to 7-11 , 19 67 , that (I) (we) last saw the deceased alive on 7-11-67 , 19 67 , and that death occurred at 2:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Joseph C. Fitzgerald		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) Joseph C. Fitzgerald		22d. ADDRESS Medical Center Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-14-67	
23c. NAME OF CEMETERY OR CREMATORY Carey's Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Sussex, Del.	
24. FUNERAL DIRECTOR A. Douglas Moran, Frankford, Del.		25a. REC'D BY REGISTRAR DATE JUL 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10262

CERTIFICATE OF DEATH

10261

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 304 Elizabeth St.	
3. NAME OF DECEASED (Type or print) First HELEN Middle JOHNSON Last HURLEY		4. DATE OF DEATH Month JULY Day 24 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1891
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 4 Days 3 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Purnell		14. MOTHER'S MAIDEN NAME Hannah C. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 100-100000000	
17. INFORMANT Mildred Vincent		Address Delmar Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerosis DUE TO (c) cardio vascular disease		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/20/1967 to 7/24/1967 that (I) (we) last saw the deceased alive on 7/24/1967 and that death occurred at 11:07 M, from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE [Signature]		22c. PHYSICIAN'S NAME (Type) [Signature]	
22d. ADDRESS [Signature]		22e. ADDRESS [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/67	
23c. NAME OF CEMETERY OR CREMATORY H. Stephens		23d. LOCATION (City or Town) (County) (State) Delmar Sussex Del.	
24. FUNERAL DIRECTOR William Morrel		25a. REC'D BY REGISTRAR JUL 26 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10263

CERTIFICATE OF DEATH

10262

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 607 Camden Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 607 Camden Avenue			
3. NAME OF DECEASED (Type or print) First CARMEN Middle AGNES Last HYNES				4. DATE OF DEATH Month July Day 10 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Control Officer		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) B.W.I. West Indies			
13. FATHER'S NAME Frank I. Nobrega		14. MOTHER'S MAIDEN NAME Carmen DeFrance					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 054-22-8911		17. INFORMANT Address Mr. Michael J. Hynes (Husband) 607 Camden Avenue, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive metastatic Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) of breast (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 mos -		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 2/27/67 to 7/10/67 , 19 53 , that (I) (we) last saw the deceased alive on 7/8/67 , 19 53 , and that death occurred at 5:30 M, from the causes and on the date stated above.					
22e. SIGNATURE William P. Sadler		22c. PHYSICIAN'S NAME (Type) Dr. William P. Sadler, Jr.		22d. ADDRESS Medical Center, Salisbury, Maryland			
22a. ATTENDING PHYS. <input checked="" type="checkbox"/> 22b. MED. DIRECTOR <input type="checkbox"/> 22c. STAFF PHYS. <input type="checkbox"/> July 11/1967		22f. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			
23d. LOCATION (City, town or county) (State) Salisbury, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND					
25a. REC'D BY REGISTRAR DATE JUL 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10264

CERTIFICATE OF DEATH

10263

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 3 Mos. 7 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS Centreville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle May Last Jackson				4. DATE OF DEATH Month July Day 16 Year 19 67			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1892	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CANNERY		11. BIRTHPLACE (County & State, or foreign country) Middletown, Delaware	
13. FATHER'S NAME Enoch Truitt				14. MOTHER'S MAIDEN NAME Rose Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-01-8729		17. INFORMANT - SON Oliver H. Wilson, 810 Monroe St., Wilmington, Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix c Pelvic Metastasis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 5 Years ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/10/67 , 19__ to 7/16/67 , 19__, that (I) (we) last saw the deceased alive on 7/16/67 , 19__, and that death occurred at 7:25 AM from causes and on the date stated above.							
22a. SIGNATURE L. Malve, M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 16, 1967	
22c. PHYSICIAN'S NAME (Type) L. Malve, M. D.				22d. ADDRESS Deer's Head State Hospital, Box 2018, Salisbury			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City or Town) (County) (State) Centreville, Q.A.Co. Md.	
24. FUNERAL DIRECTOR John H. Barling, Barling Bros, Centreville, Md. 21617				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10384
1953

1. Name: John Doe
2. Date of birth: 15.12.1925
3. Place of birth: Copenhagen
4. Nationality: Danish
5. Occupation: Teacher
6. Address: 123 Main Street, Copenhagen
7. Signature: [Signature]
8. Date: 10.1.1953
9. Place: Copenhagen
10. Authority: Ministry of the Interior

11. Remarks: None
12. Issued by: [Signature]
13. Date: 10.1.1953
14. Place: Copenhagen
15. Authority: Ministry of the Interior

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10265

CERTIFICATE OF DEATH

10264

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 8 W. East St			
3. NAME OF DECEASED (Type or print) BETHY LOUISE Jewell				4. DATE OF DEATH Month July Day 31 Year 1967			
5. SEX Female		6. COLOR OR RACE Wh. Fe		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1929	
9. AGE (In years last birthday) 38 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME William A. Elliott			
14. MOTHER'S MAIDEN NAME Catherine Mitchell				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 213-22-7876				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from ruptured esophageal varices 5811 DUE TO (b) Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Alcoholism.				INTERVAL BETWEEN ONSET AND DEATH 5 mins Not Known Not Known			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/31, 1967 to 7/31, 1967 that (I) (we) last saw the deceased alive on 7/31, 1967 and that death occurred at 8:30 PM , from causes and on the date stated above.				22a. SIGNATURE [Signature]			
22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) [Signature]			
22d. ADDRESS				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/3/67		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Gms		23d. LOCATION (City or Town) (County) (State) Delmar Sussex Del.	
24. FUNERAL DIRECTOR William M. Marvel				25a. REC'D BY REGISTRAR DATE AUG 3 1967			
25b. REGISTRAR'S SIGNATURE [Signature]				25c. REGISTRAR'S SIGNATURE [Signature]			

DECLARATION OF DEATH

50263

Twinsburg General Hospital

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Social Status		Other	
John Doe		Male		45		1/1/1910		New York		New York		Heart Disease		Natural		Teacher		High School		Catholic		Married		Middle Class			
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Social Status		Other		Signature of Registrar		Signature of Witness		Signature of Witness	
1/1/1950		10:00 AM		Twinsburg General Hospital		Heart Disease		Natural		Teacher		High School		Catholic		Married		Middle Class				John Doe		John Doe		John Doe	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL STATISTICS ACT, CHAPTER 100, SECTION 100.01, OF THE CALIFORNIA STATUTES, AS AMENDED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10266

CERTIFICATE OF DEATH

10265

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberia Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>Howard M. Johnson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIBRARY MD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LIBRARY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joshua Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 1918</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>McKinley Johnson</u>		Address <u>Washington D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Lung metastasized.</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exp. Legality</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>67</u> to <u>7-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-2</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>N.W. Todd</u>		22b. DATE SIGNED <u>7-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>N.W. Todd</u>		22d. ADDRESS <u>Med. Cor. Salisbury</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LIBERIA MD. CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>MARION MD</u>
24. FUNERAL DIRECTOR <u>Anthony E. Ward Crisfield MD.</u>		25. REG. BY REGISTRAR <u>JUL 11 1967</u>	
26. REGISTRAR'S SIGNATURE <u>James Judge</u>		27. DATE <u> </u>	

1288

STATE OF TEXAS

White House

July 1901

Handwritten notes and signatures

Handwritten notes and signatures

Handwritten notes and signatures

Handwritten notes and signatures

Handwritten notes and signatures

Handwritten notes and signatures

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TO INCLUSIVE OF MARCH 31, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10267

CERTIFICATE OF DEATH

10266

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 2909 Garden Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Baby Boy) First Middle Last Kayes				4. DATE OF DEATH Month Day Year July 10 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Baby WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1967	
9. AGE (In years last birthday) yrs. 0		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Bernard Kayes	
14. MOTHER'S MAIDEN NAME Michelle (Unk.)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9, 1967 to 7/10, 1967 , that (I) (we) last saw the deceased alive on 7/10, 1967 , and that death occurred at 11:30 PM , from causes and on the date stated above.							
22a. SIGNATURE D. G. Anderson				22b. DATE SIGNED July 12/1967		22c. PHYSICIAN'S NAME (Type) Dr. D. G. Anderson	
22d. ADDRESS Medical Center, Salisbury, Maryland				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 13 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MD A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10268

CERTIFICATE OF DEATH

10267

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EDWARD Kelly</u>		4. DATE OF DEATH Month Day Year <u>July 8 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>11 29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Sussex County, Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Kelly</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Nickman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>(219-07-4277)</u>		17. INFORMANT <u>Mrs. Maggie E. Kelly (Wife)</u> <u>Powellville, Maryland</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, Renal Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1967</u> , to <u>July 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>7:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		22b. DATE SIGNED <u>7-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill, Jr.</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Powellville, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS

1908

No.	Name of Plant	Locality	Collector	Date	Height	Fl. Color	Fr. Color	Notes
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PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10269

CERTIFICATE OF DEATH

10268

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood		d. STREET ADDRESS 02-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle Kalb Last Kalb		4. DATE OF DEATH Month July Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 10, 1893
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Lothian, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace B. Moreland		14. MOTHER'S MAIDEN NAME Alveta Wilkerson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. 212-32-2367A	
17. INFORMANT Mrs Alveta W. Catterton		Address Harwood Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-27 , 19 67 to 7-28 , 19 67 , that (I) (we) last saw the deceased alive on 7-28 , 19 67 , and that death occurred at 10:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE W. B. Collier, Jr.		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 31 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt Zion		23d. LOCATION (City or Town) (County) (State) Lothian AA Md.	
24. FUNERAL DIRECTOR J A Hardesty		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 7 1967	

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2352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10270

CERTIFICATE OF DEATH

10269

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Delmar</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Delmar</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>205 East St</i>				d. STREET ADDRESS <i>205 East St</i>			
3. NAME OF DECEASED (Type or print) <i>JULIA CARLINE LEGATES</i>				4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 4, 1886</i>	9. AGE (In years last birthday) <i>80</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				13. FATHER'S NAME <i>Hugh Phippen</i>			
14. MOTHER'S M maiden name <i>Northa Calloway</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i> (If yes give year or dates of service) <i>22-34-9408</i>			
16. SOCIAL SECURITY NO. <i>22-34-9408</i>				17. INFORMANT <i>Georgia Legates</i> Address <i>Delmar, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> <i>331X</i> DUE TO <i>Cerebral arterio-sclerosis</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>-</i> DUE TO (c) <i>-</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>8 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Degenerated heart disease</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1967</i> to <i>July 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 1, 1967</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>L.V. Sohler</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>L.V. Sohler</i>	
22d. ADDRESS <i>Delmar, Del.</i>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/5/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Acremon Cem</i>		23d. LOCATION (City, town or county) (State) <i>Thorplown, Wicomico, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William M. Mordel</i> ADDRESS <i>Delmar Del</i>				25a. REC'D BY REGISTRAR <i>JUL 6 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10320

CERTIFICATE OF DEATH

10320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Long Last Long		4. DATE OF DEATH Month July Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1894
9. AGE (In years, last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 13 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10b. KIND OF BUSINESS OR INDUSTRY Quarries	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mack Wainwright		14. MOTHER'S MAIDEN NAME Mary?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-1687	
17. INFORMANT Helen Jones		Address Inscala Ave. Salis. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 67 to 7/13 , 19 67 , that (I) (we) last saw the deceased alive on 7/13 , 19 67 , and that death occurred at 12:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE		22d. ADDRESS MEDICAL CENTER, SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-67	
23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR Loretta B. Golley		25a. REC'D BY REGISTRAR JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

80

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10272					10271					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Fayette					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown			75-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) OLIVE MARY LUCAS					4. DATE OF DEATH July 15 1967					
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8 1885		9. AGE (In years lost birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (County & State, or foreign country) Green Co. Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Freeman Kelly					14. MOTHER'S MAIDEN NAME Mary Sharpnack					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Miss Christine Lucas Snow H. II, Md.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Acute Toxic Reaction DUE TO Arteriosclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis, Acute; Mental Trauma								INTERVAL BETWEEN ONSET AND DEATH 1 day Yes		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 67 to 7/15 , 19 67 that (I) (we) last saw the deceased alive on 7/14 , 19 67 , and that death occurred at 4:30 M. from causes and on the date stated above.										
22a. SIGNATURE Rufus S. GARNER JR.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/15/67	
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARNER JR.					22d. ADDRESS MEDICAL CENTER, SALISBURY MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Sylvan Heights		23d. LOCATION (City or Town) (County) (State) Uniontown Pennsylvania				
24. FUNERAL DIRECTOR Norman F. Thomas, Snow H. II, Md.					25a. REC'D BY REGISTRAR JUL 18 1967		25b. REGISTRAR'S SIGNATURE James Judge			

10373

EXTRACT OF DATA

Mr. [illegible]

10373

[Faint, mostly illegible text, possibly a list or report, with some handwritten notes and a large circular stamp in the center.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1-66

10273

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10272

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station 19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (First) E. MANUEL (Middle) Last		4. DATE OF DEATH July Month 10 Day 1967 Year	
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1898 68 yrs.
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaford Worker	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaford Worker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) New Church, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ned Manuel		14. MOTHER'S MAIDEN NAME Lyda Stockley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO.		16. SOCIAL SECURITY NO. 214-01-1959	
17. INFORMANT Florine Manuel		Address Marion Sta., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcin lung (2) & DUE TO metastasis to brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 10 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/6 , 19 67 , to 7/10 , 19 67 , that (I) (we) last saw the deceased alive on 7-7 , 19 67 , and that death occurred at 10:30 M, from causes on the date stated above.			
22a. SIGNATURE Nevins W. Todd		22b. DATE SIGNED 7-12-67	
22c. PHYSICIAN'S NAME (Type) NEVINS W. TODD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF July 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Ward Memorial	23d. LOCATION (City or Town) (County) (State) Marion Sta, Somi Md.
24. FUNERAL DIRECTOR Norma J. Ward		25a. REC'D BY REGISTRAR DATE JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

10274

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10273

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 DAS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEWES RURAL		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Naomi First J. Middle Marsh Last		4. DATE OF DEATH July 18 1967 Month July Day 18 Year 1967	
5. SEX FEM	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 23, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME W. W. JOHNSON		14. MOTHER'S MAIDEN NAME JARAH HORNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 221-24-8690	
17. INFORMANT MR. CHARLES A. MARSH		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4:00 DUE TO Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery DUE TO ulcer (c)			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bleeding			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-11, 1967 to 7-18, 1967 , that (I) (we) last saw the deceased alive on 7-18, 1967 , and that death occurred at 2:01 AM , from causes and on the date stated above.			
22a. SIGNATURE W. B. Ellis		22b. DATE SIGNED 7-18-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JUL. 22, 1967	BETHEL METHODIST	LEWES, DEL.
24. FUNERAL DIRECTOR Hill Funeral Home		25a. REC'D BY REGISTRAR JUL 21 1967	
Address Salisbury, MD		25b. REGISTRAR'S SIGNATURE James F. Baker	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10275 CERTIFICATE OF DEATH 10274

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>All Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>320 Delaware Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>I</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>18</u> Hours <u>18</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington N.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gloatie Murphy</u> Address <u>320 Delaware Ave Salisbury</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Indefinite</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19 July 1967</u> to <u>18 July 1967</u> , that (I) (we) last saw the deceased alive on <u>18 July 1967</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>22 July 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>F.A. Curran, MD</u>				22d. ADDRESS <u>652 W Main; Salisbury, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury-Wicomico Md</u>	
24. FUNERAL DIRECTOR <u>Louetta B. Jolley</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>Ex 222 Salisbury, Md</u>				DATE <u>JUL 28 1967</u>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 209 West Main Street						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron d. STREET ADDRESS 209 West Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ISAAC WALTER MURRAY						4. DATE OF DEATH Month July Day 26 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5/ 1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Month 11 Day 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac James Murray						14. MOTHER'S MAIDEN NAME Annie Jenkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-36-5209		17. INFORMANT Mrs. Bernice M. Cooper (Sister) 209 W. Main Street - Hebron, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from July 1967 to Aug 1967 that (I) (we) last saw the deceased alive on July 1967 , and that death occurred at App-8:05P.M. from the causes and on the date stated above.											
22a. SIGNATURE John G. Bulkeley 22c. PHYSICIAN'S NAME (Type) Dr. John G. Bulkeley						22b. DATE SIGNED July 26 / 1967 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Pine Bluff Road-Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 30/1967		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery (Old Section) Mardela, Maryland				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR JUL 31 1967 25b. REGISTRAR'S SIGNATURE Charles Judge					

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 801 W. BENTON STREET, BALTIMORE, MARYLAND

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Aug. 25, 1907

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Resided at home

Resided at home

James James James

Annie Jenkins

21-36-5202 Street - Section - Maryland

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21-36-5202

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10277

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10276

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 700 East Church St.			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Walter N. Nickerson				4. DATE OF DEATH Month Day Year July 31, 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1892	9. AGE (In years lost birthday) yrs. 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (County & State, or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Nickerson				14. MOTHER'S MAIDEN NAME Emma Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-1348		17. INFORMANT Mr. Cecil F. Tull (Friend) 629 Truitt St., Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1450 Carcinoma of left lung DUE TO (b) Metastatic from tonsillar fossa carcinoma (left) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1450						INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 17, 19 67 , to July 31, 19 67 , that (I) (we) last saw the deceased alive on July 31, 19 67 , and that death occurred at 9:08 AM from causes and on the date stated above.							
22a. SIGNATURE Charles H. Winnacott				22b. DATE SIGNED 7/31/67		22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M. D.	
22d. ADDRESS Deer's Head State Hosp., Salisbury, Md.				22e. REC'D BY REGISTRAR DATE AUG 4 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
102778					10277				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 402 East Lincoln Avenue					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 402 E. Lincoln Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First RAYMOND Middle CLAYTON Last Parker			4. DATE OF DEATH Month July Day 26 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26/1900		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY House Painting			11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Brown Parker					14. MOTHER'S MAIDEN NAME Helen Parker Parker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-10-3901		17. INFORMANT Mrs. Lottie L. Parker (Wife) 402 East Lincoln Ave. Salisbury, Maryland 21801				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary arteriosclerosis (c) 1 yr OUE TO OUE TO								INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to July 26 , 19 67 , that (I) (we) last saw the deceased alive on July 23 , 19 67 , and that death occurred at 10:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE L. V. Sohler					22b. DATE SIGNED July 26 /1967		22c. PHYSICIAN'S NAME (Type) L. V. Sohler		
22d. ADDRESS Delmar, Del					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 29/1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR JUL 31 1967				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

10252

Location

Salisbury

902 East Lincoln Avenue

RAYMOND ELLISON

Male White

Fingerprints

William Ellison Parker

No

402 E. Lincoln Ave.

Salisbury

Location

Sept. 2, 1900

William Ellison Parker

William Ellison Parker

Mr. William Ellison Parker, 175 West
Lincoln Ave., Salisbury, Maryland 1907

SALE BY ORDER OF THE COURT

WILLIAM ELLISON PARKER

Salisbury, Maryland

JUL 21 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
102779					10278				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY WICOMICO MARYLAND					a. STATE MARYLAND b. COUNTY WICOMICO				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRUITLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WICOMICO NURSING HOME					d. STREET ADDRESS 221				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
			EMORY C. PAYNE			JULY 2		19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 28, 1881		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SOMERSET CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSHUA PAYNE					14. MOTHER'S MAIDEN NAME MARY STRAUSS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MRS ADDIE F. PAYNE		Address FRUITLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 67 , to 7/1 , 19 67 , that (I) (we) last saw the deceased alive on 7/1 , 19 67 , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE Calvin S. Sully					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 7/5/1967		23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEMETERY		23d. LOCATION (City, town or county) (State) REHOBETH, MD.		
24. FUNERAL DIRECTOR LEVIN R. WILSON					ADDRESS PRINCESS ANNE, MD.		25a. RECEIVED BY REGISTRAR JUL 8 1967		
					25b. REGISTRAR'S SIGNATURE [Signature]				

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EMORY

NOV. 28, 1981

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MARY WATKINS

LORENA RAYE

MRS. AGNES J. WATKINS

NO

Central Records

Handwritten signatures and dates

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10280

CERTIFICATE OF DEATH

10279

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 79 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deershead State Hospital			d. STREET ADDRESS P.O. Box 51		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HATTIE B. PETERSON			4. DATE OF DEATH Month 7 Day 28 Year 1967		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 7 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Talbot, Md.	
13. FATHER'S NAME Enos Hall			14. MOTHER'S MAIDEN NAME Mary Elizabeth Banks		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-16-1061A		17. INFORMANT Marshall Banks, Oxford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Diabetic Mellitus DUE TO Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH days yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 10 , 1967, to July 28 , 1967, that (I) (we) last saw the deceased alive on July 28 , 1967, and that death occurred at 2:50 AM , from causes and on the date stated above.					
22a. SIGNATURE Andrew C. Mitchell			22b. DATE SIGNED 7/28/67		22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 7-31-67		23c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery
24. FUNERAL DIRECTOR Barbara L. O'Connell, 426 Dover St., Easton, Md.			25a. REC'D BY REGISTRAR AUG 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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CERTIFICATE OF DEATH

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10281

CERTIFICATE OF DEATH

10280

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>192</u>	
3. NAME OF DECEASED (Type or print) First <u>Reba</u> Middle <u>Nannie</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1887</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Adams</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Ellen Paradise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harold Powell, Princess Anne, Md.</u>	
17. INFORMANT <u>Harold Powell, Princess Anne, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebellar Hemorrhage.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive CV Disease.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>Not Known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/27/67</u> , 19 <u>67</u> to <u>7/28/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/27/67</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monokin Presbyterian</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne Som., Md.</u>
24. FUNERAL DIRECTOR <u>Lever R. Wilson, Princess Anne</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATE OF NEW YORK

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VR A15 (4)
20 M 1/66

<div> <div>10282</div> <div> Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> <div>10281</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>80 Peninsula General Hospital</u>					d. STREET ADDRESS <u>Rt. 4 Johnson Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sitha R. Pugh</u>					4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Apr. 21, 1882</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John L. Ratilff</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Mudder</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>721-14-6727</u>		17. INFORMANT Address <u>Mrs. Dorothy Miller Pittsville, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Gastrointestinal Hemorrhage. Intestinal Obstruction</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1967</u> to <u>July 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 7, 1967</u> , and that death occurred at <u>3:58</u> AM, from causes and on the date stated above.									
22a. SIGNATURE <u>David J. [Signature]</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Wallace</u>					22d. ADDRESS <u>Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mc Colley's Meth. Ch. Cem. Georgetown, Del.</u>			23d. LOCATION (City or Town) _____ (County) _____ (State) _____		
24. FUNERAL DIRECTOR <u>Thomas F. Wallace</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10283

STATE OF MASS.

IN SENATE,
January 10, 1907.

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1906.

ALBANY:
PRINTED BY THE
STATE OF MASS.
1907.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10283

CERTIFICATE OF DEATH

10282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u> d. STREET ADDRESS <u>R.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE F. RAYNE</u>			4. DATE OF DEATH Month Day Year <u>JULY 21 1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 6, 1883</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POWELLVILLE MD</u>			
13. FATHER'S NAME <u>EDWARD PERDUE</u>			14. MOTHER'S MAIDEN NAME <u>JENNIE PENNEWELL</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. HENRY RAYNE POWELLVILLE MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> 443X DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7-1-67</u> , 19 <u>67</u> to <u>7-21-67</u> , that (I) (we) last saw the deceased alive on <u>7-19-67</u> , and that death occurred at <u>11</u> P. M., from causes and on the date stated above.					
22a. SIGNATURE <u>Clifford E. Schott</u>			22b. DATE SIGNED <u>7-21-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott MD</u>		
22d. ADDRESS <u>BERLIN, MD.</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PERDUE'S</u>			
23d. LOCATION (City or Town) (County) (State) <u>POWELLVILLE WIC MD</u>		24. FUNERAL DIRECTOR ADDRESS <u>Anna A. Burbage Berlin Md</u>					
25a. REC'D BY REGISTRAR DATE <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10284

Item # 0 Film # G391 7/26/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10283

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN tb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 243 West Side Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle EDGAR Last RHODES				4. DATE OF DEATH Month 7 Day 19 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-18 47		9. AGE (In years lost birthday) 19 yrs.	IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Edgar Rhodes				14. MOTHER'S MAIDEN NAME Julia B. Patterson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 267-84-6241		17. INFORMANT Mrs. Julia B. Rhodes 243 West Side Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, left 982X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple abscesses of peritoneal cavity DUE TO (c) Stab wounds of thorax and abdomen						INTERVAL BETWEEN ONSET AND DEATH 25 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed by assailant.					
20c. TIME OF INJURY Month, Day, Year 10:50 Hour XX p.m. 6-24-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3rd Street		20f. (City or town) (County) (State) Ocean City, Worcester, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED July 20, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/23/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.	
24. FUNERAL DIRECTOR Wm. C. Horst Rest Haven Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR JUL 24 1967 DATE			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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[Handwritten signature]

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JUL 2 1932

W. C. Hunt

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10285

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10284

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 419 S. Augusta Ave	
3. NAME OF DECEASED (Type or print) First Joseph J. Middle Rizzo Last 30		4. DATE OF DEATH Month July Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31 1912
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Oasis	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gennaro Rizzo		14. MOTHER'S MAIDEN NAME Maria Landolfi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-2851	
17. INFORMANT Mrs. Joseph J. Rizzo		Address (419 S. Augusta Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery D- (c) Not Known		INTERVAL BETWEEN ONSET AND DEATH 25 min 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphosarcoma - Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26/1967 to 7/30/1967 that (I) (we) last saw the deceased alive on 7/30/1967 , and that death occurred at 2:15 M, from causes and on the date stated above.		22a. SIGNATURE [Signature]	
22b. PHYSICIAN'S NAME (Type) Frank DellaVecchia		22c. DATE SIGNED 7-30-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 2nd 1967	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City or Town) (County) (State) 5608 Dogwood Rd Md.	
24. FUNERAL DIRECTOR Frank DellaVecchia		25. REC'D BY REGISTRAR Charles Judge	
26. DATE AUG 1 1967		27. REGISTRAR'S SIGNATURE [Signature]	

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1234567891011121314151617181920212223242526272829303132333435363738394041424344454647484950515253545556575859606162636465666768697071727374757677787980818283848586878889909192939495969798991001011021031041051061071081091101111121131141151161171181191201211221231241251261271281291301311321331341351361371381391401411421431441451461471481491501511521531541551561571581591601611621631641651661671681691701711721731741751761771781791801811821831841851861871881891901911921931941951961971981992002012022032042052062072082092102112122132142152162172182192202212222232242252262272282292302312322332342352362372382392402412422432442452462472482492502512522532542552562572582592602612622632642652662672682692702712722732742752762772782792802812822832842852862872882892902912922932942952962972982993003013023033043053063073083093103113123133143153163173183193203213223233243253263273283293303313323333343353363373383393403413423433443453463473483493503513523533543553563573583593603613623633643653663673683693703713723733743753763773783793803813823833843853863873883893903913923933943953963973983994004014024034044054064074084094104114124134144154164174184194204214224234244254264274284294304314324334344354364374384394404414424434444454464474484494504514524534544554564574584594604614624634644654664674684694704714724734744754764774784794804814824834844854864874884894904914924934944954964974984995005015025035045055065075085095105115125135145155165175185195205215225235245255265275285295305315325335345355365375385395405415425435445455465475485495505515525535545555565575585595605615625635645655665675685695705715725735745755765775785795805815825835845855865875885895905915925935945955965975985996006016026036046056066076086096106116126136146156166176186196206216226236246256266276286296306316326336346356366376386396406416426436446456466476486496506516526536546556566576586596606616626636646656666676686696706716726736746756766776786796806816826836846856866876886896906916926936946956966976986997007017027037047057067077087097107117127137147157167177187197207217227237247257267277287297307317327337347357367377387397407417427437447457467477487497507517527537547557567577587597607617627637647657667677687697707717727737747757767777787797807817827837847857867877887897907917927937947957967977987998008018028038048058068078088098108118128138148158168178188198208218228238248258268278288298308318328338348358368378388398408418428438448458468478488498508518528538548558568578588598608618628638648658668678688698708718728738748758768778788798808818828838848858868878888898908918928938948958968978988999009019029039049059069079089099109119129139149159169179189199209219229239249259269279289299309319329339349359369379389399409419429439449459469479489499509519529539549559569579589599609619629639649659669679689699709719729739749759769779789799809819829839849859869879889899909919929939949959969979989991000100110021003100410051006100710081009101010111012101310141015101610171018101910201021102210231024102510261027102810291030103110321033103410351036103710381039104010411042104310441045104610471048104910501051105210531054105510561057105810591060106110621063106410651066106710681069107010711072107310741075107610771078107910801081108210831084108510861087108810891090109110921093109410951096109710981099110011011102110311041105110611071108110911101111111211131114111511161117111811191120112111221123112411251126112711281129113011311132113311341135113611371138113911401141114211431144114511461147114811491150115111521153115411551156115711581159116011611162116311641165116611671168116911701171117211731174117511761177117811791180118111821183118411851186118711881189119011911192119311941195119611971198119912001201120212031204120512061207120812091210121112121213121412151216121712181219122012211222122312241225122612271228122912301231123212331234123512361237123812391240124112421243124412451246124712481249125012511252125312541255125612571258125912601261126212631264126512661267126812691270127112721273127412751276127712781279128012811282128312841285128612871288128912901291129212931294129512961297129812991300130

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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10286		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10285	
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (If deceased, if institution: Residence before admission) a. STATE Sharptown b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 820 E. Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Edward Middle Robinson Last Robinson		4. DATE OF DEATH Month July Day 14 Year 1967			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/4/1879		9. AGE (In years lost birthday) yrs. 87		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico Maryland	
13. FATHER'S NAME James Robinson		14. MOTHER'S MAIDEN NAME Lizellen Kinnikin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-7875 A		17. INFORMANT Mrs. Mary E. Robinson Address Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration and fever DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Days Weeks Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June , 1967, to July 14 , 1967, that (I) (we) last saw the deceased alive on July 13 , 1967, and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Thomas P. Sigbee		22b. DATE SIGNED July 14, 1967		22c. PHYSICIAN'S NAME (Type) Thomas P. Sigbee	
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/1967		23c. NAME OF CEMETERY OR CREMATORY Firemen's Cemetery	
23d. LOCATION (City or Town) (County) (State) Sharptown, Md.		24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Sharptown, Md.			
25a. REC'D BY REGISTRAR DATE JUL 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1952

STATE OF TEXAS

County of _____

City of _____

Department of _____

Office of _____

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

x

San Antonio, Texas

San Antonio, Texas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10287

CERTIFICATE OF DEATH

10286

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Apt. 619 Wicomico Hotel</u>	
3. NAME OF DECEASED (Type or print) <u>MARGUERITE Robinson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 1925</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russell County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Everett W. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Allie Kate Sword</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>414-34-8557</u>	
17. INFORMANT Mr. <u>Clarence Stump</u> (Brother-in-law) <u>1346 Dewey Ave., Kingsport, Tenn.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphoscoliosis and Cardiac Hypertrophy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1967</u> to <u>July 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 3, 1967</u> , and that death occurred at <u>5:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>		22b. DATE SIGNED <u>July 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill, Jr.</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Memorial Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Lebanon, Virginia</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

DECLARATION OF DEATH

10-20-68

THIS DECLARATION OF DEATH IS MADE BY THE UNDERSIGNED, WHO IS A PERSON QUALIFIED TO MAKE SUCH A DECLARATION, AND WHO HAS BEEN ADVISED BY A CLERGYMAN OR A PHYSICIAN OF THE DEEDS AND CONSEQUENCES OF THE SAME.

I, the undersigned, do hereby certify that the above-named person has died, and that the death has occurred at the place and on the date stated above.

I, the undersigned, do hereby certify that the above-named person has died, and that the death has occurred at the place and on the date stated above.

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THIS DECLARATION OF DEATH IS MADE BY THE UNDERSIGNED, WHO IS A PERSON QUALIFIED TO MAKE SUCH A DECLARATION, AND WHO HAS BEEN ADVISED BY A CLERGYMAN OR A PHYSICIAN OF THE DEEDS AND CONSEQUENCES OF THE SAME.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10288

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10288

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Box 163	
3. NAME OF DECEASED (Type or print) WILLIAM First Middle Last SCOTT		4. DATE OF DEATH Month 7 Day 25 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 1 1881
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Smith		14. MOTHER'S MAIDEN NAME Sarah E. Webster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Cooper Abbott		Address Fruitland Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic urinary tract infection DUE TO (c) Right renal stag horn calculus			INTERVAL BETWEEN ONSET AND DEATH 1 week Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 , to July 25 , 1967, that (I) (we) last saw the deceased alive on July 25 , 19 67 , and that death occurred at 3:00 M, from causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 7/25/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/28/67	23c. NAME OF CEMETERY OR CREMATORY St Johns Cem	23d. LOCATION (City or Town) (County) (State) Deal deland funeral md
24. FUNERAL DIRECTOR William J. Morrow		25a. REC'D BY REGISTRAR DATE JUL 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

1056

STATE OF TEXAS

IN SENATE,
January 10, 1907.

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE

FOR THE
YEAR
1906

AND
FOR THE
YEAR
1907

AND
FOR THE
YEAR
1908

AND
FOR THE
YEAR
1909

AND
FOR THE
YEAR
1910

AND
FOR THE
YEAR
1911

W. D. Mitchell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 4. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10289

CERTIFICATE OF DEATH

10289

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>1945 Cedarway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OLIN</u> First <u>WOODBERRY</u> Middle <u>SESTER</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed Taxi CAB</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi CAB</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Durham Co., N. Carol.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. S. Sester</u>		14. MOTHER'S MAIDEN NAME <u>Bulah Sester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>344-07-5268</u>	
17. INFORMANT <u>Mrs. P. W. Sester</u>		Address <u>- See #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <u>Hypertensive Cardio Vascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>July 31</u> , 19 <u>66</u> , to <u>July 11</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>July 11</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		22b. DATE SIGNED <u>July 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOS. C. HILL, JR. M.D.</u>		22d. ADDRESS <u>Vine Bluff Rd. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/13/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bowens Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Salisbury, Md.</u>
24. FUNERAL DIRECTOR <u>Thos. C. Hill Jr. - Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

3280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10290

CERTIFICATE OF DEATH

10280

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 4 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloxom Rural Mears			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA SCOTT SHREVES				4. DATE OF DEATH Month Day Year JULY 18 1967			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1914		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Accomack Co. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hurley Scott				14. MOTHER'S MAIDEN NAME Monnie Custis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address F. Vincent Shreves Bloxom, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to pericardium, myocardium and lungs DUE TO (b) Carcinoma of cervix DUE TO (c) Congestive Heart Failure, Malnutrition. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Congestive Heart Failure, Malnutrition.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/19 , 19 67 to 7/18 , 19 67 that (I) (we) last saw the deceased alive on 7/18 , 19 67 , and that death occurred at 7:20 M, from causes and on the date stated above.			
22a. SIGNATURE Rufus S. Garin		22b. DATE SIGNED 7/19/67		22c. PHYSICIAN'S NAME (Type) RUFUS S. GARIN, M.D.		22d. ADDRESS MEDICAL CENTER, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/67		23c. NAME OF CEMETERY OR CREMATORY Modest Town Cemetery		23d. LOCATION (City or Town) (County) (State) Modest Town Accomack Va.	
24. FUNERAL DIRECTOR John J. Williams				25a. REC'D BY REGISTRAR JUL 24 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

DEPARTMENT OF HEALTH

10230

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10291

CERTIFICATE OF DEATH

10291

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLARDS</u>		c. LENGTH OF STAY IN It		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLARDS</u>		221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>SMITH</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WILLARDS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNEST W. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>ROSA MORRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-30-7845</u>		17. INFORMANT <u>OSCAR SMITH</u> Address <u>WILLARDS MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disruption of Liver with Encephalopathy</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chol. Bright's</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1967, to <u>July 13</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 13</u> , 1967, and that death occurred at <u>4 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Chas R Law</u>				22b. DATE SIGNED <u>7-15 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Berlin Md</u>	
22d. ADDRESS		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOP</u>		23d. LOCATION (City or Town) (County) (State) <u>WILLARDS Wic. MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>				25a. REC'D BY REGISTRAR <u>Berlin Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10292

CERTIFICATE OF DEATH

10292

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodes Point		19.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle S. Last Sneada		4. DATE OF DEATH Month July Day 17 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 12, 1901
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Rhodes Point, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bradshaw		14. MOTHER'S MAIDEN NAME Angie Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-6892	
17. INFORMANT Mrs. Jean Pearson, Same as 2. abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas, Liver + Gall bladder (Primary uncertain) DUE TO (b) 1992 DUE TO (c) 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 26, 1967 to July 17, 1967 , that (I) (we) last saw the deceased alive on July 16, 1967 , and that death occurred at 530 M, from causes and on the date stated above.			
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED July 17, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr., M.D.		22d. ADDRESS Pine Bluff Road, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Rhodes Point Cemetery		23d. LOCATION (City or Town) (County) (State) Rhodes Point, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		25. REC'D BY REGISTRAR JUL 21 1967	
25a. REGISTRAR'S SIGNATURE [Signature]			

10093

COAST GUARD OF DEATH

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF MARINE SERVICE
WASHINGTON, D. C.

NAME

AGE

DATE

SEX

PLACE OF BIRTH

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

BY

REPORTED BY

NAME

ADDRESS

DATE OF REPORT

TIME

PLACE

REMARKS

SIGNATURE

DATE

PLACE

10093

REMARKS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Johnson's Lake		d. STREET ADDRESS 1018 Margaret St.	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle HENRY Last SPARKS		4. DATE OF DEATH Month 7 Day 17 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1952
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Charles Sparks		14. MOTHER'S MAIDEN NAME Mary Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walter C. Sparks, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 9298 DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned.	
20c. TIME OF INJURY Month, Day, Year 1 Hour 10 p.m. 7-17-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Johnson's Lake		20f. (City or town) (County) (State) Salisbury, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED July 18, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-21-1967	23c. NAME OF CEMETERY OR CREMATOR Union Greenbackville	23d. LOCATION (City or Town) (County) (State) Worcester County, Md.
24. FUNERAL DIRECTOR Robert A. Watson		25a. REC'D BY REGISTRAR JUL 24 1967	
ADDRESS Watson Funeral Home, Pocomoke, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

58924

49

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10294

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10294

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 714 East Road			
3. NAME OF DECEASED (Type or print) First MILDRED Middle STEPHANIE Last STANLEY				4. DATE OF DEATH Month 7 Day 14 Year 1967			
5. SEX Female	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-27	9. AGE (In years lost birthday) yrs. 39	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME MARION PRICE				14. MOTHER'S MAIDEN NAME LOTTIE CUFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-26-4922		17. INFORMANT LOTTIE PRICE		Address SALISBURY MD 21080	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, spontaneous, left 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Sub-acute bacterial endocarditis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED July 17, 1967	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-18-67		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md	
24. FUNERAL DIRECTOR West Funeral Home, Salisbury, Md.				25a. REC'D BY REGISTRAR JUL 20 1967		25b. REGISTRAR'S SIGNATURE J. C. Jones	

OFFICE OF THE ATTORNEY GENERAL

1900

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Handwritten signature or initials.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10295

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10295

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d. STREET ADDRESS 102 Delaware Ave.			
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle EDWARD Last STEVENS				4. DATE OF DEATH Month 7 Day 19 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-42	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY Glasgow & Davis		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alphonso Stevens				14. MOTHER'S MAIDEN NAME Eleanor Wootten			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 222-24-2795		17. INFORMANT Address Mrs. Eleanor Cline, Delmar, Md. (mother)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, traumatic 983X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit on back of head with pool cue stick by assailant.					
20c. TIME OF INJURY Month, Day, Year 6:30 Hour 7-19-67 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wagon wheel		20f. (City or town) (County) (State) Salisbury, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED July 21, 1967					
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		Address (Street, city, town, or county) 109 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-67		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel Del.	
24. FUNERAL DIRECTOR ADDRESS Marvel Funeral Home, Delmar, Del.				25a. REC'D BY REGISTRAR DATE JUL 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10002

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JUL 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10296

CERTIFICATE OF DEATH

10296

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>IRA</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATERMAN</u>	9. AGE (In years last birthday) <u>74</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>ELLA CURTIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Jesse Thomas Seal Island Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 - Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>15 min -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerosis moderate & blood in heart - report 10-30-67</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nor While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-22</u> , 19 <u>67</u> , to <u>7-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-2</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>N.W. Todd</u>		22b. DATE SIGNED <u>7-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>N.W. Todd</u>		22d. ADDRESS <u>Med. Off. Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WENONA Som MD</u>
24. FUNERAL DIRECTOR <u>Leroy Webster Prince Anne Md</u>		25. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of", "in", "to", "from" are visible.]

10 MONTHS OF SERVICE
IN THE
U.S. ARMY
1914-1918
1919-1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove orange papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10297

CERTIFICATE OF DEATH

10297

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>326 N. Division St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>326 N. Division St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>HANDY</u> Last <u>WAILES</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug, 22, 1866</u>
9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Protestant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ebenezer L. Wailes</u>		14. MOTHER'S MAIDEN NAME <u>Anna Todd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Miss Laura Wailes</u>		Address <u>See #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchitis pneumonia</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aspiration pneumonia - Bronchitis pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>7-12-1967</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> 1967, and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Philip A. Insley, Sr.</u>		22b. DATE SIGNED <u>7-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip A. Insley, Sr.</u>		22d. ADDRESS <u>E. Main St. Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/15/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>Hill Funera.l Home</u>		ADDRESS <u>Salisbury, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10298

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10298

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Market Street	
3. NAME OF DECEASED (Type or print) First MARY Middle FRANCES Last WEBB		4. DATE OF DEATH Month JULY Day 20 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (County & State, or foreign country) Nashville, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fredrick Ratcliffe		14. MOTHER'S MAIDEN NAME Elizabeth May Jett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-3738	
17. INFORMANT Mr. William W. Webb (Husband) Market Street, Laurel, Delaware		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of the esophagus, 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Heart DUE TO (c) Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/14/67 , 19 67 to 7/20 , 19 67 , that (I) (we) last saw the deceased alive on 7/19/67 , 19 67 , and that death occurred at 1253 M, from causes and on the date stated above.			
22a. SIGNATURE Carrie Hearn M.D.		22b. DATE SIGNED July 20, 1967	
22c. PHYSICIAN'S NAME (Type) CARRIE HEARN		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MINISTRY OF FINANCE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10299

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10299

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 417 State Street		d. STREET ADDRESS 417 State Street	
3. NAME OF DECEASED (Type or print) First LINDA Middle BETH Last WELLS		4. DATE OF DEATH Month July Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1967
9. AGE (In years last birthday) 0 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl Stanley Wells		14. MOTHER'S MAIDEN NAME Barbara Pearl Shockley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Earl S. Wells (Father)		Address 417 State Street, Sharptown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of vomitus DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN DEATH IN INFANCY.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-29-67 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) own home		20f. (City or town) (County) (State) Sharptown, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED July 31 / 1967	
EXAMINER'S NAME (Type) Earl L. Royer, M.D., Salisbury, Md.		Address (Street, city, town, or county) 409 Camden Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

12-16

10300

10300

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>Adm. in 1d</u> <u>6/20/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> d. STREET ADDRESS <u>R.D.#1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RUSSELL WILLIAM WELLS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1917</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsville, Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George William Wells</u>				14. MOTHER'S MAIDEN NAME <u>Cora Ellen McCabe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-3922</u>		17. INFORMANT Address <u>Mrs. Laura C. Wells (Wife)</u> <u>R.D.#1, Pittsville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma of the Prostate Gland</u> DUE TO (b) <u>Adenocarcinoma of the Stomach</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 25, 1967</u> to <u>JULY 12, 1967</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William B. Long</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Long</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pittsville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pittsville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u> <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE			

1. FURNACE COMPANY, 241 BROADWAY, NEW YORK

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JOHN W. 1937 NEW YORK COMPANY

1. FURNACE COMPANY, 241 BROADWAY, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10301

CERTIFICATE OF DEATH

10301

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.D.#1 Riverside Dr. Ext.	
3. NAME OF DECEASED (Type or print) First LEVI Middle PARSON Last WHITE		4. DATE OF DEATH Month JULY Day 27 Year 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19/1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming (Retired)	
11. BIRTHPLACE (County & State, or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph White		14. MOTHER'S MAIDEN NAME Williana Seabrease	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-28-3646A	
17. INFORMANT Mrs. I. Estelle White (Wife)		Address R.D.#1 Riverside Dr. Ext. Salisbury, Md. 21801	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Rt Lower Lobe 350X DUE TO (b) Prostatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Parkinsonism		INTERVAL BETWEEN ONSET AND DEATH Yes Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Malnutrition & Dehydration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/20 , 19 66 to 7/27 , 19 67 , that (I) (we) last saw the deceased alive on 7/27 , 19 67 , and that death occurred at 10:55 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Dr. Rufus S. Gardner		22b. DATE SIGNED July 28/1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 30/1967	
23c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		23d. LOCATION (City or Town) (County) (State) Siloam, Maryland (Wico, Co)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10302

CERTIFICATE OF DEATH

10302

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1b 6/22/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Rt. #5, Quantico Road	
3. NAME OF DECEASED (Type or print) First VERNON Middle LEROY Last White		4. DATE OF DEATH Month July Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1902
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 0 Days 17 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (County & State, or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Purnell D. White		14. MOTHER'S MAIDEN NAME Sallie Bounds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-1076	
17. INFORMANT Mrs. Lillian White (Wife)		Address Rt. #5, Quantico Road, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis obliterans 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carotid artery insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour 2:50 a.m. 7-17-67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-7 , 19 67 , to 7-17 , 19 67 that (I) (we) last saw the deceased alive on 7-17 , 19 67 and that death occurred at 2:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. E. Kent Carney		22b. DATE SIGNED 7-17-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. Kent Carney		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 20 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

10303

DEPARTMENT OF HEALTH

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

THIS IS A PRELIMINARY REPORT. IT IS NOT TO BE USED FOR
LEGAL PURPOSES. IT IS SUBJECT TO CHANGE AND SHOULD NOT
BE USED FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10303

Item #9 Film #G391 8/11/67 ph

CERTIFICATE OF DEATH

10303

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby First Middle Last WHITTINGTON		4. DATE OF DEATH Month Day Year JULY 18 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/67
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years lost birthday) yrs. 6 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Crisfield Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WALLACE BIVENS		14. MOTHER'S MAIDEN NAME Bernice Whittington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - Atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity - 1# 12oz DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 18, 1967 to July 18, 1967 , that (I) (we) last saw the deceased alive on July 18, 1967 , and that death occurred at 4:35 P M, from causes and on the date stated above.			
22a. SIGNATURE William C. Morgan		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/67	
23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION (City or Town) (County) (State) Crisfield Md.	
24. FUNERAL DIRECTOR Anthony E. Ward		25a. REC'D BY REGISTRAR DATE AUG 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

7-254862

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
10304					10304					
7-25-67 ams					Item 8 Film G390 7/20/67 kk					
Reg. Dist. No.										
1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke RT. 3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Beth Eden Curch Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>RING</u> Last <u>WIDDOWSON</u>					4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1902</u> <u>Sept. 19, 1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John M. Ring</u>					14. MOTHER'S MAIDEN NAME <u>Callie Cooley</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. E.R. gladding</u>			Address <u>See 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, traumatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from ladder</u>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>AM</u> p. m. <u>7-12</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home</u>		20f. (City or town) <u>Pocomoke</u>		(County) <u>Worcester</u>		
								(State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>					DATE SIGNED <u>7-13-67</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/15/1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Memory Garden</u>			22d. LOCATION (City, town, or county) <u>Hebron, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill</u>					ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10305

CERTIFICATE OF DEATH

10305

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. LENGTH OF STAY IN 1b 221	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 507 Liberty Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CHANDLER Last Wilkinson		4. DATE OF DEATH Month July Day 26 Year 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8/1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 11 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Employee Breakman		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co., Maryland	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Orlando Wilkinson		14. MOTHER'S MAIDEN NAME Alice Truitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-6301	
17. INFORMANT Mrs. Inez L. Wilkinson (Wife)		Address 507 Liberty Street-Salisbury, Maryland 21801	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiration of Vomitus DUE TO 611X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suppurative gastritis July 24/67 (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 7:16 , 19 67 to 7:20 , 19 67 , that (I) (we) last saw the deceased alive on 7-26 19 67 and that death occurred at 10A M, from causes and on the date stated above.			
22a. SIGNATURE A. H. Briele		22b. DATE SIGNED 7-26-67	
22c. PHYSICIAN'S NAME (Type) A. H. Briele		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 31, 1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR AUG 1 1967	
25b. REGISTRAR'S SIGNATURE J. H. H. H.		25c. REGISTRAR'S SIGNATURE J. H. H. H.	

10302

STATE OF TEXAS

County of ...

City of ...

Notary Public

My Commission Expires ...

Witness my hand and seal this ... day of ...

X

19... ..

Notary Public for the State of Texas

My Commission Expires ...

Notary Public for the State of Texas

Notary Public for the State of Texas

Notary Public for the State of Texas

Notary Public for the State of Texas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10306

CERTIFICATE OF DEATH

10306

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22-1	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 504 Booth St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beatrice Williams		4. DATE OF DEATH July 11 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-30-
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (County & State, or foreign country) Snow Hill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sadie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-28-4379	
17. INFORMANT Henry Williams		Address 504 Booth St. Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic degenerative renal disease (c) yes.		INTERVAL BETWEEN ONSET AND DEATH yes.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 67 , to 7/11 , 19 67 , that (I) (we) last saw the deceased alive on 7/11 , 19 67 , and that death occurred at 3:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles Judge		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-67	
23c. NAME OF CEMETERY OR CREMATORY Taylor's Gate		23d. LOCATION (City or Town) (County) (State) Snow Hill - Wicomico - Md.	
24. FUNERAL DIRECTOR Charles B. Taylor		25a. REC'D BY REGISTRAR DATE JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

10000

DEATH OF (NAME) (LAST, FIRST, MIDDLE)

19-10-1961

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ST. THOMAS & COMPANY, SALTSBURY, MARYLAND

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ST. THOMAS & COMPANY, SALTSBURY, MARYLAND

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10308

10309

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First <u>LIDA</u> Middle <u>M.</u> Last <u>WOOTTEN</u>				4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>12/18/1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Zadoc M. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>221-32-3122</u>		17. INFORMANT <u>Marian Smith</u> Address <u>Bethel, Delaware</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> EXAMINER'S NAME (Type)			M.D. <u>409 Camden Ave., Salisbury, Md.</u>			22. DATE SIGNED <u>July 18, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millsboro Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Millsboro, Sussex, Del.</u>	
24. FUNERAL DIRECTOR <u>Watson & Gray, Frankford, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

ATLANTIC EXHIBIT 2 (CONT.)

JUL 2 1981

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10300

10310

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>Adm. in 1d</u> <u>7/3/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Route #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA ABAGAIL WORKMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1886</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>R.D. Pittsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Azarah Brittingham</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Parker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>219-34-3428</u>		17. INFORMANT Address <u>Mr. G. Richard Workman (Son)</u> <u>Route #3, Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Hypertensive Cardio-vascular Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cardio-vascular Accident ; Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Sev. years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1967</u> to <u>July 10, 1967</u> that (I) (we) last saw the deceased alive on <u>July 10, 1967</u> and that death occurred at <u>12:15</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. G. Herbert Sembly</u>				22b. DATE SIGNED <u>July 4/1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Herbert Sembly</u>			
22d. ADDRESS <u>400 E. Church St., Salisbury, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> PM STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City, town or county) <u>Walston, Maryland</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JUL 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-67

U.S. ARMY, 2nd INFANTRY, 1st DIVISION, 1950

U.S. ARMY, 2nd INFANTRY, 1st DIVISION, 1950

U.S. ARMY, 2nd INFANTRY, 1st DIVISION, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10310

CERTIFICATE OF DEATH

10307

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Mae Willing		4. DATE OF DEATH July 18 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1885
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY ---	
12. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Samuel Carey		15. MOTHER'S MAIDEN NAME Annie Ewell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. SOCIAL SECURITY NO. 220-01-9562	
18. INFORMANT Sanders Willing, Pocomoke City, Md.		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-7 , 19 67 , to 7-18 , 19 67 , that (I) (we) last saw the deceased alive on 7-18 , 19 67 , and that death occurred at --- M, from causes and on the date stated above.			
22a. SIGNATURE Wilbur R. Ellis, Jr. MD		22b. DATE SIGNED 7-18-67	
22c. PHYSICIAN'S NAME (Type) Wilbur R. Ellis, Jr., MD		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-20-1967	
23c. NAME OF CEMETERY OR CREMATOR Salem Methodist		23d. LOCATION (City or Town) (County) (State) Pocomoke City Wor. Md.	
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR JUL 24 1967	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
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